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DRUG ABUSE IN THE UNITED STATES ARMY*

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DRUG abuse is a serious problem across the nation. Several days ago a senior United States senator described it as the current number one health problem in the United States. Certainly it has been increasingly prominent in the medical news of the last five years. The Deputy Chief New York Medical Examiner recently reported that the use of heroin has become the leading cause of death among teen-agers in New York City. Large urban areas attribute much of the rise in crime to the increase in use of hard drugs, and many larcenies are accomplished in order to serve the "150-a-day habit" of the drug-dependent individual. The term "epidemic" would seem to apply to abuse of drugs on college campuses, which yield questionnaire responses indicating that more than 40% of the students have had recent personal experience with drugs such as marijuana, heroin, "speed," barbiturates, and the like. Into an era of long-awaited miracle drugs come shadow-opposites, the "uppers" and "downers," the needle "fix" of heroin, and the pot

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party. "Better living through chemistry!" is the satirical theme of today's drug psychology. Much has been written about the counter-culture behavior of our nation's youth, about political dissent and dissatisfaction with the establishment and with cultural values. There is a confidence gap. This is appreciated in a most exquisite fashion by those in uniform, many of them fighting and dying in a war that lacks measurable popular support. When even the meaningful combat action is tempered with organizational "stand-downs" and major programs of phased withdrawal, leisure time weighs heavily, and drug abuse, as a symptom of "copping out," of increased psychological vulnerability, needs only to be facilitated. Recently almost pure heroin became available in Vietnam in large quantities, and at an unusually low price, even for Asia. This has been associated with a sharply increased rate of hospitalization for drug abuse, and increased numbers of deaths, especially from heroin.

There are a number of reasons for the Army's relatively recent awareness of the extent of the drug-abuse problem in addition to the fact of its very rapid development. In the past, the provision of a *current count* of patients suffering from drug-related conditions has not been regarded as a mission-related requirement from our statisticians. Available evidence indicated that such patients represented a very small proportion of the hospital workload, while consideration of military personnel policies indicated that a small proportion of drug users would become patients in the course of processing their separation from the military service. Hence such data were not required for medical management or planning, nor could they have been used for measuring the prevalence of drug abuse in the Army. Consequently neither statisticians nor consultants proposed that the medical department system of current summary reports (e.g., the morbidity report) should include a count of admissions for drug-related conditions, and such counts are not available to us at this time. When individual medical records are processed, information about admissions for a specific diagnosis, including drug-related conditions, will be available. At this time, however, there is a large backlog of unprocessed records. To prevent such backlogging in the future, the Surgeon General decided early in 1970 to develop and install a new system for obtaining required data from clinical records. Responsibility was assigned to a new office of Patient Care Administration in the Directorate of Plans, Supply, and Operations.

This new, individual-data system, which involves decentralized coding and computer tabulations of medical information, was installed on January 1, 1971. At monthly intervals thereafter, counts of patients treated in hospitals or in their quarters for drug-related conditions as well as for other specific diagnoses will be made available to the Office of the Surgeon General.

Necessarily, our most supportable statistical measurements have been based primarily on Criminal Investigation files. To be more direct, we have a measure of the number of soldiers who were investigated for drug offenses. In 1967, 4.8% of the cases received at the criminal investigative repository for filing were drug cases. The percentage rose to 27.4 in 1968 and to 37.4 in 1969. Recognizing that available Army statistics reflect only those individuals who are investigated for abusing drugs, some commands have conducted anonymous surveys by questionnaire in an effort to estimate the number of personnel who have used drugs illegally.

A survey of prisoners at the Long Binh Stockade in Vietnam in June 1967[1] found that among those prisoners who had been convicted for other than drug offenses, 63% admitted having used marijuana at least once, the majority before arrival in Vietnam. Of those prisoners who were confined for marijuana offenses, 80% had first used this drug in civilian life. The population studied in this survey was not representative of any military unit; it was merely a sample of a population of military prisoners. Another survey was conducted in Vietnam over a three-month period during the fall of 1967 and sampled nearly 4% of the men leaving the two southern corps areas for return to the United States during the period.[2] This survey showed that 31.7% of the respondents to a questionnaire had used marijuana at some time during their lifetimes. It is interesting to note that a smaller percentage—28.9%—admitted using marijuana while in Vietnam. From January through April 1969 a team of three researchers conducted a survey of more than 5,000 enlisted men at Fort Sill, Okla.[3] Twenty-nine per cent of the respondents admitted having used drugs at some time during their lifetimes. Of the admitted users, 83% had used marijuana and 5% had used heroin.

In a survey conducted at Fort Carson, Colo., during the spring of 1970,[4] 684 individuals completed questionnaires. It was found that 20% of the respondents were using some drugs more than once a week, and that an additional 5.6% were using drugs more than once a month but

less than once a week. The survey indicated that men at Fort Carson who had returned from Vietnam did not exhibit a significantly different degree of drug abuse than other members of the military surveyed.

In the autumn of 1969 another survey of drug usage was conducted in Vietnam,[5] including over 1,000 men entering and 1,000 men departing from the country. Preliminary results show that 31% of the soldiers arriving in Vietnam have used marijuana, while 46% of those leaving have used it. Only 13% of the total sample can be considered as heavy users of marijuana—having used it more than 20 times.

The most recently completed survey in Vietnam was conducted in the 173d Airborne Brigade in March 1970.[6] A total of 1,064 soldiers completed questionnaires; 68% of them acknowledged the use of marijuana at some time during their lifetimes. Questions as to the frequency of use were also asked. It was found that 31% of the total sample used marijuana at least once a week. This 31% was about equally divided as to frequency; slightly more than half were categorized as regular users—more than four times a week—and the remainder as irregular users—not more than four times a week. Twenty-two per cent of the sample first tried marijuana in Vietnam.

Of the other illegal drugs used, only opium appeared as a frequent drug of abuse. Sixty-three soldiers—approximately 6% of the 173d Airborne sampling—admitted that they were regular users of opium. This is especially disturbing.

There has been an increase in the number of deaths from drug use in Vietnam, although the total number is still very small in proportion to the military population. In the period from August 1 to October 18 of 1970, there were 11 drug-related deaths confirmed by autopsy. Physicians suspected an additional 64 drug-related deaths; however, this could not be confirmed by autopsy. In all of 1969 there were only 11 deaths confirmed by autopsy and, in the first seven months of 1970, 14 deaths. This recent rise in deaths of soldiers in Vietnam because of the use of heroin parallels the rise in deaths from overdosage among youth all over the country. The Army, like other responsible agencies, has striven to prevent such needless fatalities. However, the Army has been confronted with a very special problem in Vietnam—a large influx of highly potent yet inexpensive heroin.

Investigators from the Armed Forces of the United States have collaborated with official Vietnamese investigators in an attempt to inter-

cept and reduce the supply of this deadly strain of heroin. In addition, stricter controls of medical supplies in Thailand and elsewhere have been undertaken. The Command in Vietnam is also widely publicizing the deadly nature of this heroin in order to alert unsuspecting troops. It is hoped that these measures will reduce the number of soldiers hospitalized because of heroin and those who die from having used it. Reasons for the increase are easy to discern:

1) The civilian sector of society appears to be undergoing a change in attitudes toward drugs.

2) Despite some pronouncements to the contrary, marijuana is looked upon by many citizens as no more harmful than alcohol. A recently published survey of medical students in attendance at four schools indicated that more than 50% of them have used marijuana in the past, while 30% of those questioned said they were presently using marijuana.

Criminal sanction may invite rather than deter usage for those seeking a thrill. Criminal sanctions against the use of marijuana may make it easier psychologically for persons once they have tried marijuana to try narcotic drugs as well, since they have already broken the law.

3) Many of those who use marijuana in the Army have used it previously.

4) The supply of marijuana and opiates in Vietnam and elsewhere, despite our efforts, has not been choked off. At this point it is important to state that although the use of marijuana and other drugs has increased, it is not known to have interfered with, nor do we expect it to interfere with, the military effectiveness of our units of squad size or larger. On the contrary, general observations by medical and other personnel in Vietnam suggest that users of marijuana refrain from smoking on offensive combat operations. Incidents believed to be caused by the abuse of drugs are essentially individual actions, such as refusals to obey orders, rather than group offenses. Although the requirements of missions continue to be met, this should not be interpreted as minimizing the Army's concern over the problems of drug abuse.

A recently completed analysis of the clinical summaries of all psychiatric admissions to a large Army general hospital on the East Coast[7] reveals that during 1962 only 1% of more than 400 admissions had drug-related causes. A similar number of admissions in 1968 were analyzed, and 20% of these had drug-related causes. In 1969 this factor increased to 25%.

While all offenses involving the abuse of drugs are felonies, Army policy has been realistic and responsive in the face of the growing problem of drug abuse. Although Army treatment of offenders had been punitive traditionally, the interest of the Command in drug education as a preventive measure began in early 1967. Requirements were developed for initial orientation and training before departure overseas. It is evident that commanders throughout the Army are expending great efforts in educating their troops about the abuse of drugs.

This past policy of restraint in separating administratively or punitively soldiers engaged in drug abuse is reinforced by the recently promulgated regulation governing the use of drugs in the Army. I believe that the statement of policy in this regulation is worthy of attention as an accurate description of the Department of the Army's efforts, attitudes, and approach toward the handling of soldiers engaged in drug abuse.

> . . . It is the policy of the Department of the Army to prevent and eliminate drug abuse and to attempt to restore and rehabilitate members who evidence a desire and willingness to undergo such restoration. The illegal or improper use of drugs by a member of the Army may have a seriously damaging effect on his health and mind, may jeopardize his safety and the safety of others, may lead to criminal prosecution and discharge under other than honorable conditions, and is altogether incompatible with military service or subsequent civilian pursuits. The Department of the Army acknowledges a particular responsibility for counseling and protecting its members against drug abuse and for disciplining members who use or promote the use of drugs in an illegal or improper manner.
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> . . . Appropriate disciplinary and administrative actions in cases of drug abuse will be dependent upon all the facts and circumstances of each case and will include consideration of whether the individual involved is a drug experimenter, drug user, drug addict, supplier, or casual supplier. . . .

As pointed out in the statement of policy that is included in the new regulation, the administrative or disciplinary action that is taken in a particular case depends on numerous factors.

The Command in the past has exercised common sense in dealing with the drug problems confronted, but with the increase in drug usage

it became apparent that additional guidance was needed; hence the new regulation. In writing the Army regulation emphasis was placed on striking a balance between the enforcement, the purely legal aspects of drug abuse, and the more humane, individual aspects. The key policy statement in the regulation stresses that the Department of the Army will continue efforts to prevent and eliminate the abuse of drugs, while attempting also to restore and rehabilitate soldiers who express a desire and willingness to undergo such restoration. The rehabilitation portion is designed to help those soldiers using drugs before we catch them and embark on the costly process of investigation, judgment, and confinement.

The concept is patterned after Army programs currently in effect in several areas of the world. I shall briefly describe just three of these:

Fourth Infantry Division (RVN). An amnesty program began in May 1969. An addict not under investigation could turn himself in to the surgeon, chaplain, or provost marshal. Immunity was granted. All drug-counseling records were kept in the office of the division chaplain. Very little was written, though a medical evaluation was provided. Very little hospitalization was considered necessary. Soldiers came because the hard drugs scared them. They feared they could not stop. They feared they would end up on some high-risk list and be unable to find employment. They feared that their families would reject them.

All the addicts in the program were quickly returned to the units from which they had come. Each then cooperated in picking out a Big Brother among peers, noncommissioned officers, or officers. Individual counseling on a weekly basis was arranged by the division psychiatrist and the division chaplain. Gradually the division built up a small group of ex-addicts who felt responsible to help others, and to spread the word about the amnesty program. One ex-addict made an interesting tape about how it felt to go through the program. This was copied and circulated. This is the form of the program at the present time (in RVN).

Fort Benning, Ga. Benning House is a half-way house for those who abuse alcohol and other drugs; it was started originally for the treatment of alcoholism alone. It presently comprises two barracks buildings and one converted mess hall; a fourth building is being readied. Patients are admitted to a four-bed detoxification unit in the hospital, are withdrawn from drugs, and are quickly discharged back to duty status; but in this program they work in their units by day, have family and group-

activity programs in the evening, and sleep in the half-way house. Each individual is programmed for 90 days of retraining in this model, then is transferred completely back to barracks or home, and continues treatment in the outpatient clinic of the hospital. The half-way house program is active five nights a week.

A major augmentation in support of personnel, specialized training, and renovation of facilities has been supported recently by the Commanding General there.

Fort Bragg, N. C.: Operation Awareness. In the early spring of 1970 the Commanding General, XVIII Airborne Corps, set up a Drug Abuse Council. He instituted an educational program for his high-ranking officers first. The full impact of education is not expected to hit the lowest troop level for several more months. All the work was concentrated on hard drugs. While marijuana was not condoned, no witch-hunts were undertaken.

As many as 12 patients at one time, those usually mainlining heroin and one or two other drugs concurrently, are placed on an operant conditioning program in a special ward. The patient is withdrawn from his drug and placed in group therapy. He progresses to an outpatient program developed along the coffeehouse model called the Rap-House, where others not yet in the program who have anxiety or curiosity about drugs can verbally allay their tensions and still not feel "captured" by the establishment. The Rap-House is the recruiting center for volunteers for the rehabilitation program.

A special facet of the program provides several weeks of training for line soldiers who are specially interested in drug-abuse issues. These trainees become available for counseling in their units and are called Awareness Counselors. It is intended that every company-sized unit will eventually have one.

We are currently proposing establishment of Alcohol and Drug Dependency Intervention Councils (ADDIC) in each large post to increase emphasis on public education, earliest referral of cases, community support of police and legal challenges of the drug traffic, and support of medical and command-led programs of treatment and rehabilitation. We feel that alcohol and drug abuse are sufficiently similar phenomena as not to warrant a duplication of bureaucracies by separate agencies for alcohol and drug abuse. In addition, formal training in the medical and social aspects of drug abuse which relate to program devel-

opment is recommended for nonmedical resource professionals as well, at the training centers at Yale University, the University of Oklahoma, and Hayward College in California, sponsored by the Department of Health, Education, and Welfare.

In conclusion, I think it is clear that the Army, in conjunction with the Department of Defense Drug Abuse Control Committee, has acted rapidly and vigorously to meet the challenge of controlling drug abuse.

The problem of controlling drug abuse is not insoluble, but neither is it simple. We are currently wrestling with a number of attendant questions: how to improve screening at the Armed Forces Examining Stations, how to refer the drug addict or ex-addict effectively to ongoing treatment when he is administratively separated from the Army, and a whole host of questions relating to the Army's internal operations.

The Army recognizes the need for concern for the individual soldier who mistakenly abuses drugs and requires assistance in rehabilitation, subject to the paramount requirement of maintaining a disciplined effective fighting force.

The program that I have outlined attempts to achieve this objective by demonstrating a concern for the individual without sacrificing the needs of the Army or of the nation.

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